Testimony of

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on a

MEDICARE PRESCRIPTION DRUG BENEFIT

before the

HOUSE WAYS & MEANS COMMITTEE

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Chairman Archer, Congressman Rangel, distinguished Committee members, thank you for holding this hearing to discuss Medicare prescription drug coverage. Your Health Subcommittee-s hearing on this issue last month was highly constructive, and we welcome the opportunity this hearing provides to further our bipartisan dialogue. We are encouraged by the growing commitment embodied in the new House Republican proposal to address this issue. We want to continue working with you to enact legislation that meets the principles President Clinton laid out earlier this year.

Background

As we know, pharmaceuticals are as essential to modern medicine today as hospital care was when Medicare was created. Lack of prescription drug coverage among senior citizens today is similar to the lack of hospital coverage among senior citizens when Medicare was created. Three out of five beneficiaries lack dependable coverage. Only half of beneficiaries have year-round coverage, and one third have no drug coverage at all.

Those without coverage must pay for essential medicines fully out of their own pockets, and are forced to pay full retail prices because they do not get the generous discounts offered to insurers and other large purchasers. The result is that many go without the medicines they need to keep them healthy, out of the hospital, and living longer lives.

Drug coverage is not just a problem for the poor. More than half of beneficiaries who lack coverage have incomes above 150 percent of the federal poverty level. Millions more have insurance that is expensive, insufficient, or highly unreliable. Even those with most types of coverage find it costs more and covers less. Copayments, deductibles, and premiums are up.

And coverage is often disappearing altogether as former employers drop retiree coverage, Medigap is becoming less available and more expensive, and managed care plans have severely limited their benefits. Clearly all beneficiaries need access to an affordable prescription drug coverage option.

KEY PRINCIPLES

The President has identified key principles that a Medicare drug benefit must meet, and we are willing to

support proposals that meet these principles. It should be:

- **Voluntary and accessible to all beneficiaries.** Medicare beneficiaries in both managed care and the traditional program should be assured of an affordable drug option. Since access is a problem for beneficiaries of all incomes, ages, and geographic areas, we must not limit a Medicare benefit to a targeted group. At the same time, those fortunate enough to have good retiree drug benefits should have the option to keep them.
- **Affordable to beneficiaries and the program.** We must ensure that premiums are affordable enough so that all beneficiaries participate. Otherwise, primarily those with high drug costs would enroll and the benefit would become unstable and unaffordable. And beneficiaries must have meaningful protection against excessive out-of-pocket costs.
- **Competitive and have efficient administration**. Medicare should adopt the best management approaches used by the private sector. Beneficiaries should have the benefit of market-oriented negotiations.
- **Ensuring access to needed medications and encouraging high-quality care.** Beneficiaries should have a defined benefit that assures access to all medically necessary prescription drugs. They must have the assurance of minimum quality standards, including protections against medication errors.
- **Consistent with broader reform.** The drug benefit should be consistent with a larger plan to strengthen and modernize Medicare.

THE PRESIDENT'S PLAN

The President has proposed a comprehensive Medicare reform plan that meets these principles. It includes a voluntary, affordable, accessible, competitive, efficient, quality drug benefit that will be available to all beneficiaries. The President's plan dedicates over half of the on-budget surplus to Medicare and extends the life of the Medicare Trust Fund to at least 2030. It also improves access to preventive benefits, enhances competition and use of private sector purchasing tools, helps the uninsured near retirement age buy into Medicare, and strengthens program management and accountability.

The President=s drug benefit proposal makes coverage available to all beneficiaries. The hallmark of the Medicare program since its inception has been its social insurance role. Everyone, regardless of income or health status, gets the same basic package of benefits. This is a significant factor in the unwavering support for the program from the American public and must be preserved. All workers pay taxes to support the Medicare program and therefore all beneficiaries should have access to a new drug benefit.

A universal benefit also helps ensure that enrollment is not dominated by those with high drug costs (adverse selection), which would make the benefit unaffordable and unsustainable. And, as I described earlier, lack of drug coverage is not a low-income problem B beneficiaries of all incomes face barriers.

The benefit is completely voluntary. If beneficiaries have what they think is better coverage, they can keep it. And the President's plan includes assistance for employers offering retiree coverage that is at least as good as the Medicare benefit to encourage them to offer and maintain that coverage. This will help to minimize disruptions in parts of the market that are working effectively, and it is a good deal for beneficiaries, employers, and the Medicare program. We expect that most beneficiaries will choose this

new drug option because of its attractiveness, affordability, and stability.

For beneficiaries who choose to participate, Medicare will pay half of the monthly premium, with beneficiaries paying an estimated $26 per month for the base benefit in 2003. The independent HCFA Actuary has concluded that premium assistance below 50 percent would result in adverse selection and thus an unaffordable and unsustainable benefit.

Premiums will be collected like Medicare Part B premiums, as a deduction from Social Security checks for most beneficiaries who choose to participate. Low-income beneficiaries would receive special assistance. States may elect to place those who now receive drug coverage through Medicaid into the Medicare drug program instead, with Medicaid paying premiums and cost sharing as for other Medicare benefits.

We would expand Medicaid eligibility so that all beneficiaries with incomes up to 135 percent of poverty would receive full assistance for their drug premiums and cost sharing. Beneficiaries with incomes between 135 and 150 percent of poverty would pay reduced premiums on a sliding scale, based on their income. The Federal government will fully fund States' Medicaid costs for the beneficiaries between 100 and 150 percent of poverty.

Under the President's plan, Medicare will pay half the cost of each prescription, with no deductible. The benefit will cover up to $2,000 of prescription drugs when coverage begins in 2003, and increase to $5,000 by 2009, with 50 percent beneficiary coinsurance. After that, the dollar amount of the benefit cap will increase each year to keep up with inflation. For beneficiaries with higher drug costs, they will continue to receive the discounted prices negotiated by the private benefit managers after they exceed the coverage cap. To help beneficiaries with the highest drug costs, we are setting aside a reserve of $35 billion over the next 10 years, with funding beginning in 2006.

Benefit managers, such as pharmacy benefit manager firms and other eligible companies, will administer the prescription drug benefit for beneficiaries in the traditional Medicare program.

These entities will bid competitively for regional contracts to provide the service, and we will review and periodically re-compete those contracts to ensure that there is healthy competition. The drug benefit managers -- not the government -- will negotiate discounted rates with drug manufacturers, similar to standard practice in the private sector.

We want to give beneficiaries a fair price that the market can provide without taking any steps toward a statutory fee schedule or price controls. The drug benefit managers will have to meet access and quality standards, such as implementing aggressive drug utilization review and patient counseling programs. And their contracts with the government will include incentives to keep costs and utilization low while assuring a fairly negotiated contractual relationship with participating pharmacists.

Similar to the best private health plans in the nation, virtually all therapeutic classes of drugs will be covered. Each drug benefit manager will be allowed to establish a formulary, or list of covered drugs. They will have to cover off-formulary drugs when a physician certifies that the specific drug is medically necessary. Coverage for the handful of drugs that are now covered by Medicare Part B will continue under current rules, but they also may be covered under the new drug benefit once the Part B coverage is exhausted.

The President's plan also strengthens and stabilizes the Medicare+Choice program. Today, most

Medicare+Choice plans offer prescription drug coverage using the excess from payments intended to cover basic Medicare benefits. Under the President's proposal, Medicare+Choice plans in all markets will be paid explicitly for providing a drug benefit B in addition to the payment they receive for current Medicare benefits. Plans will no longer have to depend on what the rate is in a given area to determine whether they can offer a benefit or how generous it can be. This will eliminate the extreme regional variation in Medicare+Choice drug coverage, in which only 23 percent of rural beneficiaries with access to Medicare+Choice have access to prescription drug coverage, compared to 86 percent of urban beneficiaries.

And beneficiaries will not lose their drug coverage if a plan withdraws from their area, or if they choose to leave a plan, because they will also be able to get drug coverage in the traditional Medicare program. We estimate that plans will receive $54 billion over 10 years to pay for the costs of drug coverage.

Beneficiaries will have access to an optional drug benefit through either traditional Medicare or Medicare managed care plans. Those with retiree coverage can keep it and employers would be given new financial incentives to encourage the retention of these plans.

MEETING KEY PRINCIPLES

We are flexible on the details of how a Medicare drug benefit is provided, but the design must ensure that we meet the President=s key principles of a benefit that is voluntary, affordable, competitive and efficient. We have reviewed draft descriptions of the plan, but we have not seen the details. Based on this review, we believe the new Republican plan marks important progress. However, we believe it does not meet the President=s test of a meaningful benefit that is affordable and accessible for all beneficiaries. Key among our concerns are the apparent lack of an individual premium subsidy for all beneficiaries, an inadequate level of support, and reliance on insurers who are unlikely to participate.

Will prescription drug coverage be available? The Republican plan appears to rely extensively on participation by private insurers who have made clear that stand-alone drug policies are not feasible. Subsidizing private insurers instead of establishing a reliable Medicare benefit means that outpatient prescription drugs would not be part of the Medicare benefits package like doctor or hospital care. Beneficiary premiums would pay for expensive, private Medigap plans whose administrative costs are on average more than 10 times higher than Medicare=s, according to National Association of Insurance Commissioners statistics, rather than an affordable Medicare option. Furthermore, Medigap plans have little experience negotiating with drug manufacturers and relying on numerous plans does not pool the purchasing power of seniors; both elements are needed to keep the benefit affordable.

Building on the private Medigap insurance market would be especially difficult in sparsely populated rural areas, where risk pools are smaller and seniors are more likely to have higher costs, as a report released by the President today shows. There also is no certainty or stability in the drug coverage options in the Republican proposal. Even if some insurers do offer coverage, they would likely come in and out of the market, move to profitable areas, and significantly modify benefit design from year to year based on prior year=s experience. This would result in the same pull-outs and uncertainty we see in managed care today.

The drafts of the new proposal suggest reliance on a Afall back@ mechanism, in which the government would ensure availability everywhere. This seems to acknowledge the weakness of the drug-only insurance plans. We continue to believe that Medicare should provide drug coverage the same way that

virtually all private insurers do -- by contracting directly with pharmacy benefit managers in each region of the country. This will ensure that all beneficiaries have access and that the pharmacy benefit managers can negotiate the best prices.

Is drug coverage affordable to all beneficiaries? The Republican plan does not provide direct premium subsidies to individuals with incomes above $12,600 a year. Instead, it appears to rely on indirect subsidies of 25 to 30 percent to lower premiums. It is unclear that this amount of subsidy will ensure that affordable coverage is available to all or would be equally affordable in all regions of the country.

There are several additional areas where we have questions about the new Republican plan. These include:

- Is it a defined benefit? The Republican plan appears to allow insurers to offer an unspecified Astandard@ benefit, or an actuarial equivalent benefit. Only the stop-loss amount is specified, and insurers would set deductibles and copays.

  This could lead to beneficiary confusion and benefit packages designed for Acherry-picking@ of low-cost, healthy enrollees, with insurers offering no deductible, low copays, and a low benefit cap that leaves a large gap before the stop-loss kicks in. This would be a step backwards from the Medigap reforms of the early 1990s that standardized benefits so plans compete on price and quality rather than consumer confusion.
- Does the plan assure access to needed medications? The Republican plan appears to require insurers to cover only all Amajor@ therapeutic classes of drugs. Depending on how that is defined, and the degree to which each insurance company is permitted to define it, some seniors could be left without the medications they need. It also appears to require a beneficiary to go through a formal appeals process to get coverage of off-formulary drugs the physician deems to be medically necessary, which could limit access. Furthermore, the Republican=s multi-insurer approach breaks up the pooled purchasing power of seniors, forcing insurers to reduce costs through restrictive formularies and limited pharmacy choice.
- Will the plan increase access to coverage for rural beneficiaries? The Republican plan appears to rely on additional assistance for Medicare+Choice plans as a means of bringing those plans into rural areas where, because of sparse health care service delivery structures, managed care has often had difficulty thriving. It is not clear this will work.
- Will the proposed approach to remove international drug pricing disparities work? We agree that Americans, particularly those who now lack prescription drug coverage, should not disproportionately subsidize drug development. However, it is not clear that having the U.S. Trade Representative negotiate to address drug price controls in other nations will result in fairer prices here at home. This proposal could simply result in higher prices abroad without having an impact on the high prices American consumers now pay.

- Will the plan result in more efficient Medicare administration? We understand that the Republican plan would create a new Medicare Oversight and Management Administration (MOMA) to administer the drug benefit and the Medicare+Choice program. It appears to be adding a new layer of bureaucracy since many MOMA activities would duplicate those that HCFA would also need to continue, such as beneficiary education, resulting in duplication and ignoring HCFA=s expertise.

CONCLUSION

We may be turning a corner in our efforts to secure the Medicare drug benefit that we all agree is needed. We are nearing a workable consensus on the broader outlines of how the benefit should be structured. Critical concerns about providing an affordable, accessible, meaningful benefit and relying on private insurers remain. But we are beginning to get into the all-important, deeper details of how to make sure the benefit can succeed. While a great deal of work remains, momentum is now with us. The challenges before us can be met if we continue the constructive approach that we have, together, taken to date. And I look forward to continuing to work with you as we enter the next phase on this critical issue.

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